Senate Bill No. 1569

Passed the Senate August 26, 2004

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Secretary of the Senate

Passed the Assembly August 25, 2004

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Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of

_____, 2004, at _____ o'clock __M.

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Private Secretary of the Governor

CHAPTER _____

An act to add Section 1393.3 to the Health and Safety Code, relating to health care service plans.

LEGISLATIVE COUNSEL'S DIGEST

SB 1569, Dunn. Provider remedies.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. The act requires that a contract between a plan and a provider contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism and that reimbursement of a complete claim, which is neither contested nor denied, be made within a designated time period.

This bill would authorize a provider, as defined, to bring an action, subject to specified conditions, against a health care service plan that violates a provision of the act or its implementing regulations relating to claims processing or payment, as defined.

The people of the State of California do enact as follows:

SECTION 1. (a) The Legislature finds and declares the following:

(1) Billing by providers and claims processing by health care service plans are essential components of the health care delivery process.

(2) While providers have traditionally utilized the courts as a mechanism to seek payment relief, courts in Ochs v. PacifiCare of California (2004) 115 Cal.App.4th 782; In re Managed Care Litigation (2003) 298 F.Supp.2d 1259, and Chase Dennis Emergency Group, Inc. v. Aetna (2003) Cal.App. Unpub. LEXIS 9235, which is not an officially published case, have concluded that the payment provisions of the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code (hereafter the Knox-Keene Act)) are not directly enforceable by providers because the payment of providers is a regulatory responsibility of the Department of Managed Health Care.

(3) At the same time, the Department of Managed Health Care has interpreted the Knox-Keene Act to authorize it to impose fines on plans that on a systemic basis, fail to comply with the Knox-Keene Act payment and claims processing provisions, but that it is without authority to compel plans to pay an individual provider.

(4) If providers are unable to obtain relief from either the Department of Managed Health Care or the courts, they may be without a remedy for nonpayment of their claims and other violations of the Knox-Keene Act.

(b) It is, therefore, the intent of the Legislature to clarify that providers may maintain suits, as set forth in this act, to redress payment violations under the Knox-Keene Act. To avoid any misinterpretation, this act applies only to the payment and claims processing provisions it specifically identifies.

SEC. 2. Section 1393.3 is added to the Health and Safety Code, to read:

1393.3. (a) If a health care service plan violates a provision of this chapter or its implementing regulations relating to claims processing or payment, a provider that contracts directly with the plan may bring an action against that plan to recover contract damages plus penalties and interest in accordance with this chapter and, if appropriate, to obtain injunctive relief.

(b) If a health care service plan violates a provision of this chapter or its implementing regulations relating to claims processing or payment for a claim submitted directly to the plan, a provider may bring an action against the plan to recover quasi-contract damages, plus penalties and interest in accordance with this chapter, and, if appropriate, injunctive relief, if both of the following conditions exist:

(1) The provider has no written contract with the plan or its contracting entity.

(2) The provider has provided to the enrollee emergency medical services and care as set forth in Section 1371.4 that are covered under the enrollee's plan contract.

(c) If the provider is a shareholder, employee, partner, or contractor of a lawfully organized group practice and does not contract directly with the health care service plan or the entity that directly contracts with the health care service plan, the action may

be filed only by the group practice and not by its shareholders, employees, partners, or contractors.

(d) A provider may not maintain a cause of action pursuant to this section if the claim in dispute concerns a service that is excluded as a covered benefit from the terms and conditions of the health care service plan contract or is a disputed health care service for which independent medical review has been requested but not yet completed pursuant to Article 5.55 (commencing with Section 1374.30).

(e) For purposes of this section, the following definitions apply:

(1) ''A provision of this chapter or its implementing regulations relating to claims processing or payment'' means Section 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, or 1371.8 of this code or Section 1300.71, 1300.71.38, or 1300.71.4 of Title 28 of the California Code of Regulations.

(2) ''Provider'' means a physician and surgeon or a doctor of podiatric medicine licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, an osteopathic physician and surgeon licensed pursuant to the Osteopathic Act, or a lawfully organized group of those physicians and surgeons, podiatrists, or osteopathic physicians and surgeons.

(3) ''Quasi-contract damages'' means the reasonable value of the services rendered by the provider.

(f) Nothing in this section shall be construed to negate a contractual requirement between a plan and a provider relating to the exhaustion of contractual or administrative remedies, where applicable, or to revise or expand the scope of practice of a provider or to revise or expand the types of providers who are authorized to submit claims to, and contract with, a health care service plan.

(g) A provider may maintain a cause of action pursuant to this section only if the provider has exhausted remedies set forth in his or her contract with the plan or contracting entity that are administered and conducted by the plan or entity itself and that are available, and the provider has pursued his or her rights pursuant to Section 1367 and regulations implementing that section, where applicable.

(h) An action brought pursuant to subdivision (a) shall be governed by Section 337 of the Code of Civil Procedure. An action brought pursuant to subdivision (b) shall be governed by Section 339 of the Code of Civil Procedure.

(i) The remedies provided in this section shall be in addition to, and not in derogation of, all other rights and remedies that a provider may have under any other law.

Approved _____, 2004

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Governor